



**KENTUCKY BOARD OF
EMERGENCY MEDICAL SERVICES**
COMMONWEALTH OF KENTUCKY
2545 LAWRENCEBURG ROAD
FRANKFORT, KENTUCKY 40601
PHONE: 502-564-8963
FAX: 502-564-4687



COMPLAINT FORM

Agency Use

Form Received:

/ /20

Complaint #

Complaint filed by:

Last Name	First Name	Middle Initial	
Ambulance Service		Address (Street or P.O. Box)	
City	State	Zip Code	Fax Number: () -
County	Phone Number () -	Email Address:	

Complaint against: (EMS Provider/Agency, Ambulance Service, Fire Department, EMT, Paramedic, First Responder, Educational Institution, etc.)

<u>Name and Cert/License Number:</u>		<u>Ambulance Service and License Number:</u>	
Address (Street or P.O. Box)			
City	State	Zip Code	Fax Number: () -
County	Phone () -	Email Address:	

Description of Complaint:

(Please describe the event, circumstances, conduct and/or behavior that you believe said individual or service may have violated, or is below professional practice standards, or in violation of protocol and regulations)

(Please attach additional sheets, if needed).



"An Equal Opportunity Employer M/F/H

The Kentucky Board of Emergency Medical Services only has statutory authority to investigate complaints against individuals certified or licensed to practice or provide emergency medical services, and educational institutions that provide EMS training and education.

List names, addresses, and phone numbers of witnesses or persons who have knowledge of the event or alleged inappropriate behavior, or may have other relevant information:

Last Name		First Name		Middle Initial	
Address (street)					
City		State	Zip Code	Fax Number: () -	
County	Phone Number () -		Email Address:		
Last Name		First Name		Middle Initial	
Address (street)					
City		State	Zip Code	Fax Number: () -	
County	Phone Number () -		Email Address:		
Last Name		First Name		Middle Initial	
Address (street)					
City		State	Zip Code	Fax Number: () -	
County	Phone Number () -		Email Address:		

I affirm that information contained in this report is true and accurate to the best of my knowledge and belief.

Signature of individual making Complaint	Date
	/ /

STATE OF _____)

_____)

COUNTY OF _____)

Subscribed and sworn to before me by _____ this _____ day of _____, 20__.

My Commission Expires: _____

Notary Public

Mail Complaint to:
Kentucky Board of Emergency Medical Services
Attn: Investigations
2545 Lawrenceburg Road
Frankfort Kentucky 40601

*** THIS FORM MUST BE NOTARIZED. IF IT IS NOT NOTARIZED, IT WILL BE RETURNED TO YOU FOR NOTARY.**

(Form 1/2002)